Filing at a Glance

Company:	Government Personnel Mutual Life Insurance Company
Product Name:	MIB 2013 Authorization Change
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	10/01/2012
SERFF Tr Num:	GPML-128493653
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	LA12, ET AL
Implementation Date Requested:	On Approval
Author(s):	Linda Boydston, Norma Castillo
Reviewer(s):	Linda Bird (primary)
Disposition Date:	10/05/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Government Personnel Mutual Life Insurance Company*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *MIB 2013 Authorization Change*
Project Name/Number: *MIB 2013 Authorization Change/LA12, et al*

General Information

Project Name: MIB 2013 Authorization Change
Project Number: LA12, et al
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Linda Boydston

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/05/2012
State Status Changed: 10/05/2012
Created By: Norma Castillo
Corresponding Filing Tracking Number:

Filing Description:
This filing contains no unusual or controversial items from normal Company or industry standards.

Application forms LA12A and SLA12 are being submitted for your approval. They will replace the previously approved forms shown below.

1. LA97A, approved 12/17/1997.
2. SLA06, approved 8/26/2006

The forms were created in order to comply with the MIB 2013 Authorization change by adding, "I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB" to the authorization section in both applications.

In addition to the MIB change, LA12A has additional updates which are shown in the redline comparison between LA97A and LA12A. The comparison is attached under the Supporting Document tab.

The difference between SLA12 and SLA06 is limited to the above MIB authorization and the form number. No other changes were made.

These forms are in final print format; however, we reserve the right to change the format due to technological advances.

Company and Contact

Filing Contact Information

Norma Castillo, Regulatory Filing Assistant anc@gpmlife.com
2211 N.E. Loop 410 800-938-4765 [Phone] 2724 [Ext]
P.O. Box 659567 210-357-6722 [FAX]
San Antonio, TX 78217

State: *Arkansas* ***Filing Company:*** *Government Personnel Mutual Life Insurance Company*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *MIB 2013 Authorization Change*
Project Name/Number: *MIB 2013 Authorization Change/LA12, et al*

Filing Company Information

Government Personnel Mutual Life Insurance Company
2211 N.E. Loop 410
P.O. Box 659567
San Antonio, TX 78217
(800) 938-4765 ext. 2814[Phone]

CoCode: 63967
Group Code: 4712
Group Name:
FEIN Number: 74-0651020

State of Domicile: Texas
Company Type: LAH
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $200.00
Retaliatory? Yes
Fee Explanation: Texas Retaliatory fee for approval is $100 per form submitted separately from policy.
Per Company: No

Company	Amount	Date Processed	Transaction #
Government Personnel Mutual Life Insurance Company	$200.00	10/01/2012	63252982

SERFF Tracking #:	*GPML-128493653*	***State Tracking #:***		***Company Tracking #:***	*LA12, ET AL*

State:	*Arkansas*	***Filing Company:***	*Government Personnel Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB 2013 Authorization Change*		
Project Name/Number:	*MIB 2013 Authorization Change/LA12, et al*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/05/2012	10/05/2012

SERFF Tracking #:	*GPML-128493653*	***State Tracking #:***		***Company Tracking #:***	*LA12, ET AL*

State:	*Arkansas*	***Filing Company:***	*Government Personnel Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB 2013 Authorization Change*		
Project Name/Number:	*MIB 2013 Authorization Change/LA12, et al*		

Disposition

Disposition Date: 10/05/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Redline Differences		Yes
Supporting Document	Statement of Variability		Yes
Form	Life Application		Yes
Form	Life Application		Yes

SERFF Tracking #:	*GPML-128493653*	***State Tracking #:***		***Company Tracking #:***	*LA12, ET AL*

State:	*Arkansas*	***Filing Company:***	*Government Personnel Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB 2013 Authorization Change*		
Project Name/Number:	*MIB 2013 Authorization Change/LA12, et al*		

Form Schedule

Lead Form Number: LA12A

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		LA12A	AEF	Life Application	Initial:	51.300	LA12A.pdf
2		SLA12	AEF	Life Application	Initial:	40.700	SLA12.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Application for Life Insurance

GPM LIFE

Government Personnel Mutual Life Insurance Company
[2211 N.E. Loop 410, San Antonio, Texas 78217 1
P.O. Box 659567, San Antonio, Texas 78265 2
www.gpmlife.com] 3

PART ONE OF APPLICATION FOR LIFE INSURANCE WITH
GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY (GPM Life)

[P.O. Box 659567 San Antonio, Texas 78265-9567
(210) 357-2222 1-800-938-4765 www.gpmlife.com
Fax numbers: Local (210) 357-2235 Toll Free 1-888-701-3869]

Application Number

❑ new application ❑ policy change

A. Primary Proposed Insured (PPI)

1. Name (First, Middle Initial, Last)	2. SS/Tax ID No.	3. Birthplace (State/Country)
4. Residence Address (Including City, County, State & Zip)	5. Business Address (Including City, County, State & Zip)	
6. Mailing Address (Including City, County, State & Zip) ❑Check if same as Residence		
7. Residence Phone Number: ( )	8. Business Phone Number: ( )	
9. Driver's License No./State	10. Occupation and Nature of Duties	
11. Annual Income	12. Employer/Military Branch	13. Paygrade
13. Marital Status ❑Married ❑Single ❑Divorced ❑Separated ❑Widowed	14. If Military: Years In | ETS Date |	15. ❑Military ❑Civilian ❑Federal Civil Service

B. All Proposed Insureds List PPI first, then spouse, if applicable)

First Name Middle Last	SS/Tax ID No.	Relation to PPI	Sex M/F	Date of Birth Mo/Day/Yr	Birthplace State/Country	Height Ft. In.	Weight Lbs.
1		PPI					
2							
3							
4							
5							
6							

C. Plan of Insurance

Amount $	Plan	Age of PPI	Requested Policy Date	Mode: ❑Annual ❑SemiAnnual ❑Military Allotment ❑Civil Service Allotment ❑Electronic Funds Transfer ❑Other_____	Automatic Premium Loan Provision ❑Yes ❑No

Complete for Universal Life Plans: Option ❑A ❑B	Planned Premium $	Accidental Death Rider $	Additional Insurance Rider $
❑Waiver of Cost Insurance	❑Guaranteed Benefit Increase $	❑Children's Benefit Rider $ SS#	
❑Other Insured Rider $ on		❑Other Insured Rider $ on	
❑Other Insured Rider $ on		❑Other Insured Rider $ on	
❑Decreasing AIR		❑Other	

Complete for all other plans	**Modal Premium: $**	Dividend Option: ❑Cash ❑Reduce Premiums ❑Paid-Up Additions ❑Accumulations ❑Special Modal Dividend Option (10 YT)

Benefits/Riders:	❑Waiver of Premium	❑Accidental Death Benefit $	❑Guaranteed Insurability Option $
❑Spouse Insurance		❑Childrens Insurance Rider $ SS#	
❑Additional Term Rider $		❑Other	

❑Paid Up Additions Rider Initial Scheduled Premium $_____ 1035 Exchange
❑Unscheduled Premium $_____ ❑SemiAnnual ❑Quarterly ❑Monthly ❑Yes ❑No

D.-Life Insurance in Force on All Proposed Insureds: ❑ None ❑ Listed Below

Insured	Issue Year	Company	Face Amount	ADB

E.-Beneficiary Designation

Full Name and Address of Primary Beneficiary(ies)	Social Security/Tax ID No.	Date of Birth	Relationship to PPI

Full Name and Address of Contingent Beneficiary(ies)	Social Security/Tax ID No.	Date of Birth	Relationship to PPI

F.-Owner, if other than Primary Proposed Insured

Full Name	Social Security/Tax ID No.	Date of Birth	Relationship to PPI
Address, if other than Primary Proposed Insured's			Branch & Paygrade

Contingent Owner

Full Name	Social Security/Tax ID No.	Date of Birth	Relationship to PPI
Address, if other than Primary Proposed Insured's			Branch & Paygrade

G.-Payor, if other than Primary Proposed Insured

Full Name	Social Security/Tax ID No.	Date of Birth	Relationship to PPI
Address, if other than Primary Proposed Insured's			Branch & Paygrade

SPECIAL REQUESTS OR INSTRUCTIONS

CORRECTIONS AND ADDITIONS (FOR HOME OFFICE USE ONLY)

H.-General Information

The following questions pertain to all Proposed Insureds, including children.	*Yes*	*No*	*Explain fully all "Yes" answers. Indicate question number and the name of the Proposed Insured the answer applies to.*
1. Is the insurance applied for intended to replace any existing insurance or annuity contract?	❑	❑	
2. Are there any application(s) for any life or health insurance now pending or contemplated in any company?	❑	❑	
3. Has any Proposed Insured ever had an application for life insurance or annuity contract declined, postponed, rated or had an application issued other than as applied for?	❑	❑	
4. Is any Proposed Insured NOT a United States citizen? If "Yes", provide immigration card number_____	❑	❑	
5. Has any Proposed Insured ever received or claimed disability or a pension for any injury, sickness or impaired condition?	❑	❑	
6. In the past 5 years, has any Proposed Insured made any flight other than as a passenger or does she / he plan to make such flights in the next five years? (If "Yes", complete Aviation Questionnaire)	❑	❑	
7. In the past 5 years, has any Proposed Insured engaged in: ballooning, cave exploration, parachuting, hang gliding, vehicle racing, scuba diving below 60 feet, mountain climbing or similar sport or avocation? (If "Yes", circle activity and complete appropriate questionnaire)	❑	❑	
8. Does any Proposed Insured have any intention of traveling or living outside the USA or Canada in the next 2 years, except for vacation?	❑	❑	
9. In the past 5 years has any Proposed Insured been convicted of 2 or more moving violations, or driving under the influence of drugs or alcohol, or had a driver's license suspended or revoked? (If "Yes", give details.)	❑	❑	
10. In the past 10 years has any Proposed Insured used marijuana, cocaine, heroin, barbiturates, hallucinogens, or amphetamines, unless on the advice of a physician, or been convicted for the use or possession of alcohol; or received advice, counseling or treatment as the result of the use of alcohol or drugs; or used or been convicted for the use or possession of any narcotic, stimulant, sedative, or hallucinogenic drug?	❑	❑	
11. In the past 10 years has any Proposed Insured been convicted of a felony?	❑	❑	
12. (For military only) Does any Proposed Insured serve in Special Forces, Rangers, Airborne, or Navy SEALs?	❑	❑	

I.- Physical Data, Health and Medical History

The following questions pertain to all Proposed Insureds, including children, (Circle ALL applicable items)	*Yes*	*No*	*Explain fully all "Yes" answers. Include name of Proposed Insured and question number the answer applies to, specific diagnosis, treatments, results, dates of onset & recovery, and names & addresses of all doctors & hospitals.*
1. (a) Does any Proposed Insured currently use tobacco in any form? (If "yes", describe tobacco use below.) Who? _____ ❑ Cigarettes ___ packs per day ❑ Cigars ❑ Pipe ❑ Chewing or other "smokeless" tobacco	❑	❑	
(b) Is any Proposed Insured a former user of tobacco? (If "yes", describe tobacco use below.) Who? _____ Month/Year quit _____ Describe past use of tobacco_____	❑	❑	
2. Has any Proposed Insured ever been diagnosed with or treated for:			
(a) high blood pressure, chest pain or pressure, angina, heart attack, abnormal heartbeat, murmur, stroke, or any other circulatory system disorder?	❑	❑	
(b) cancer, Hodgkin's disease, leukemia, or any tumor or polyp?	❑	❑	
(c) epilepsy, convulsions, seizures, severe headaches, paralysis, nervous breakdown, psychosis, or any mental or nervous disorder?	❑	❑	
3. In the past 10 years, has any Proposed Insured had or been treated for:			
(a) diabetes, anemia, polycythemia, hemophilia; disorder or enlargement of any gland, including lymph glands?	❑	❑	
(b) persistent fever, cough, diarrhea, weakness or infection?	❑	❑	
(c) asthma, bronchitis, emphysema, tuberculosis, pneumonia, or any infection or other disorder of the respiratory system?	❑	❑	
(d) ulcer, gastritis, colitis, hepatitis, cirrhosis, pancreatitis, or any other disorder of liver, gallbladder, or intestines?	❑	❑	
(e) any disorder of the kidneys, bladder, prostate, reproductive organs or breasts; or any sexually transmitted disease?	❑	❑	
(f) any disorder of the back, spine, bones, joints or muscles?	❑	❑	
4. In the past 10 years has any Proposed Insured:			
(a) been diagnosed by a member of the medical profession as having, or been treated for, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV disease?	❑	❑	
(b) tested positive for antibodies to the HIV virus?	❑	❑	
5. In addition to any doctors or hospitals listed above, in the last 5 years, has any Proposed Insured:			
(a) been treated, examined or observed in a hospital, clinic, or other medical facility?	❑	❑	
(b) consulted with any other doctors?	❑	❑	
(c) been treated for, diagnosed as having, or had an operation for any other cause(s) not listed above?	❑	❑	
6. Within the past year, has the weight of any Proposed Insured changed 10 pounds or more? (For children under 16, report only loss)	❑	❑	
7. Has any family member (parents, siblings) of the proposed Insured had heart disease, stroke, diabetes or cancer prior to age 60?	❑	❑	
8.			

PPI'S Family History	*Living: age*	*Deceased: age at death*	*Cause of death*
Father			
Mother			
Brothers			
Sisters			

Received with app: $_____cash ❑Civil Service 1199A and Bank Allotment Authorization
❑Military Allotment Request Copy or Certification ❑None of the above received. The application is to be considered on a C.O.D. basis.

AGREEMENT: I have read this application, and represent that all of the information given in it is true, complete and correctly written. It is agreed that:

A. The application consists of Part One, Part Two (if required), and any amendments or supplements to either of said parts. It will be relied on by GPM Life as the basis of any policy which may be issued.

B. No agent, broker, or medical examiner can accept risks, make or change contracts, or waive any of GPM Life's rights, conditions, or requirements. Only an authorized officer of GPM Life can do these things.

C. Except as may be provided by the Conditional Receipt, there will be no insurance unless and until a policy is delivered and the first modal premium paid in full while the insurability of the Proposed Insured(s) is still as described in the application; there must have been no material change in health or other risk factors. I will notify GPM Life if any such change takes place after I sign the application and before such delivery and payment.

D. If the Conditional Receipt is delivered to the Applicant, insurance will start before a policy is delivered only if all the conditions set forth in such receipt are met. If I have received such receipt, its provisions have been explained to me and I fully understand them.

E. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for Home Office "Corrections and Additions". But where the law so requires, written consent must be obtained for any change in the application.

BACKUP WITHHOLDING CERTIFICATION (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me or my minor children, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. I further authorize all said sources, except Medical Information Bureau, Inc., to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s).

Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required.

I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 30 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled " Information Practices", "Investigative Consumer Reports", and "Medical Information Bureau, Inc." from GPM Life.

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Primary Proposed Insured (if minor, parent or legal guardian)	*** * * Date Signed * * ***	Signature of Agent
Signature of Spouse, if a Proposed Insured	Signature of Other Proposed Insured (if age 15 or over)	Agent's Printed Name / GPM Life Agent No.
Signature of Proposed Owner (if not Primary Proposed Insured)	Signature of Other Proposed Insured (if age 15 or over)	Agent's License No. / State
Signature of Other Proposed Insured (if age 15 or over)	Signature of Other Proposed Insured (if age 15 or over)	Signed at (City, State, Zip)

CONDITIONAL RECEIPT

Unless every condition in paragraph 2 is met exactly, no insurance will take effect prior to policy delivery. No agent, broker, or medical examiner is authorized to change or waive any of such conditions. If, within the past 12 months, any Proposed insured has had or been treated for any known heart trouble, stroke, AIDS or cancer, payment cannot be accepted with the application.

All checks must be made payable to GPM Life. Do not make check payable to the agent or leave the payee blank.

Received from_____$_____cash or, in lieu of cash,

❑ Military Allotment Request Copy or Certification, or ❑ Civil Service 1199A & Bank Allotment Authorization

given with application for life insurance to Government Personnel Mutual Life Insurance Company (GPM Life), which application bears the same date as this receipt. This receipt is void if the item given for it fails to result in payment.

1. If all the conditions in Paragraph 2 are met exactly, then insurance subject to the terms of the policy applied for, but not to exceed the limit in Paragraph 3, will start at the "Conditional Effective Time", defined as the later of: (a) when Part One of the application has been completed; or (b) when all medical exams and tests required by GPM Life's rules have been completed, and all required blood, urine, and/or oral fluid specimen(s) have been furnished.
2. Insurance will not start at the Conditional Effective Time unless all these conditions are met:
   (a) At the Conditional Effective Time, all of the Proposed Insureds must be risks acceptable to GPM Life under its rules, limits, and standards of insurability for the amount and plan applied for, without change, and at the standard rate of premium.
   (b) The sum of money, if any, given for this receipt must be at least as much as the full first premium for the plan, amount of insurance and the mode of payment stated in the application.
   (c) All medical exams and tests required by GPM Life's rules must be completed, and all required specimens of blood, urine, and/or oral fluid specimen(s) furnished, within 60 days from the date of Part One of the application.
   (d) At the Conditional Effective Time, the state of health and all factors affecting the insurability of the Proposed Insured(s) must be as stated in the application.
   (e) If a Military Allotment Request Copy or Certification or a Civil Service form 1199A and Bank Allotment Authority has been received by GPM Life in lieu of cash, the allotment 1) must not have been canceled or discontinued for any reason before GPM Life receives the full first monthly premium corresponding to the mode of payment stated in the application, and 2) must result in payment to GPM Life of such full first monthly premium by the earlier of the policy Effective Date or 14 weeks after the Conditional Effective Time.
3. The total amount of life insurance, including accidental death benefits, which may become effective on any Proposed Insured prior to the effective date of a delivered policy for which the full first premium has been received by reason of this and any other receipts will not exceed $150,000.
4. If one or more of the conditions in Paragraph 2 is not met exactly, or if death of a Proposed Insured results from suicide, there will be no liability on the part of GPM Life except to return any money received.

C. Alan Ferguson, Secretary

I certify that I have explained all of the terms of this receipt to the Applicant(s).

Date:_____ X_____
Signature of Agent

The following is a copy of the Agreement signed in connection with the application.

AGREEMENT

AGREEMENT: I have read this application, and represent that all of the information given in it is true, complete, and correctly written to the best of my knowledge and belief. It is agreed that:

A. The application consists of Part One, Part Two (if required), and any amendments or supplements to either of said parts. It will be relied on by GPM Life as the basis of any policy which may be issued.

B. No agent, broker, or medical examiner can accept risks, make or change contracts, or waive any of GPM Life's rights, conditions, or requirements. Only an authorized officer of GPM Life can do these things.

C. Except as may be provided by the Conditional Receipt, there will be no insurance unless and until a policy is delivered and the first modal premium paid in full while the insurability of the Proposed Insured(s) is still as described in the application; there must have been no material change in health or other risk factors. I will notify GPM Life if any such change takes place after I sign the application and before such delivery and payment.

D. If the Conditional Receipt is delivered to the Applicant, insurance will start before a policy is delivered only if all the conditions set forth in such receipt are met. If I have received such receipt, its provisions have been explained to me and I fully understand them.

E. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for Home Office "Corrections and Additions". But where the law so requires, written consent must be obtained for any change in the application.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY
AGENT'S REPORT AND CERTIFICATE

		Yes	No
1.	Is the Applicant or any Proposed Insured a current or past GPM Life policyowner or Insured?	❑	❑
2.	As far as you know, will the insurance applied for replace any existing insurance or annuity?	❑	❑
	If "Yes", did you write the replaced policy?	❑	❑
	Reason(s) for replacement:		
3.	Are there any Proposed Insureds whom you did not see when you took this application?	❑	❑
4.	Are there any Proposed Insureds who do not reside with the Primary Proposed Insured?	❑	❑
5.	Have you submitted or do you plan to submit this case to any other company?	❑	❑
6.	Has any Proposed Insured used a different last name in the past 5 years?	❑	❑
	(Provide full details of all "Yes" answers)		

7. To clarify any question or obtain a telephone interview, the following is needed **(Please remind the Primary Proposed Insured about the possibility of a call)**:

   Home Telephone: ( ) _____ Best time to call _____

   Business Telephone: ( ) _____ Best time to call _____

8. Indicate below how well you know the Primary Proposed Insured (Applicant, if Primary Proposed Insured is under age 18).

   ❑ Slightly for ____ years ❑ Well for____ years ❑ Just met ❑ Related by blood or marriage; he/she is my _____

9. Is medical exam or blood profile required? ❑ Yes ❑ No

   Date Scheduled_____ Paramed/Examiner _____

10. If Primary Proposed Insured is below 18, how much life insurance is in force and applied for on:

    Mother_____ Father_____ Siblings_____

11. Request for ❑ Additional ❑ Alternate policy.....

    Plan_____ Amount_____ Benefits _____

    Beneficiary_____ Other Differences _____

12. Source of Prospect

    ❑ Existing Client ❑ Relative of Client ❑ Referred Lead ❑ Personal Acquaintance for _____ years.

    ❑ Cold Canvas ❑ Direct Mail ❑ Prospect approached me without being solicited

AGENT'S REPORT AND CERTIFICATE

13. Use of Insurance (check one)

❑ Personal (If checked, complete question 14) ❑ Business Related (If checked, complete question 15)

14.a Purpose of Personal Insurance with expectation of how proceeds will be utilized (check one most applicable)

❑ Create an Immediate Estate for Heirs ❑ Surviving Income Protection
❑ Retirement Income Supplement ❑ Provide Estate Liquidity
❑ Mortgage Protection/Acceleration ❑ Secure Other Personal Debt
❑ Supplement and Protect Personal Savings ❑ Other_____

14.b How was amount of Personal Insurance determined? (check one most applicable).

❑ Needs Analysis with Assistance from Agent ❑ Needs Analysis with Computer Output Assistance
❑ Need Pre-Determined by Applicant ❑ Other_____

15.a Purpose of Business Insurance (check one most applicable).

❑ Business Continuation Plan (Buy/Sell) ❑ Key Person Plan ❑ Deferred Compensation Plan
❑ Split Dollar Plan ❑ Executive Bonus Plan ❑ Secure Business Debt
❑ Other_____

15.b Business Data ❑ Corporation ❑ Partnership ❑ Sole Proprietorship

If available, attach a copy of the business' latest audited financial statements (Balance Sheet and Profit and Loss).

In addition, please complete the following questions:

i. Date Corporation, Partnership or Business Established_____
ii. Estimated Net Worth of Business $_____
iii. Current Value of Primary Proposed Insured's Interest (based on % of ownership) $_____
iv. Net Annual Income of Business $_____
v. If Proposed Insured is an officer or partner, are all of the remaining officers or partners applying for insurance at this time? ❑ Yes ❑ No (if "No", explain in remarks)

REMARKS _____

_____

_____

_____

I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of any person proposed for insurance which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices, the Federal Fair Credit Reporting Act, and Medical Information Bureau, Inc., were given to the Primary Proposed Insured.

Date	Agent's Signature	Joint Agent's Signature
	Agent's Printed Name/GPM Life Agent No.	Joint Agent's Printed Name/GPM Life Agent No.
	Agent's License No./State	Joint Agent's License No./State

Government Personnel Mutual Life Insurance Company
[P.O. Box 659567 2
San Antonio, Texas 78265-9567
www.gpmlife.com] 3

NOTICE UNDER THE FAIR CREDIT REPORTING ACT AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

INVESTIGATIVE CONSUMER REPORTS: As part of the underwriting process, we may request an investigative consumer report from a consumer reporting agency for the purpose of obtaining information about your character, reputation and mode of living, through personal interviews with your friends, neighbors, and associates. You may ask for a personal interview with the consumer reporting agency in connection with any investigative consumer report which may be prepared. You are also entitled, upon written request pursuant to law, to be informed of the nature and scope of the investigation and to receive a copy of the report.

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB 7 at [866-692-6901 (TTY 866-346-3642)]. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734]. Information for consumers about MIB may be obtained on its website at [www.mib.com.] 9 8

We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

For further information, write the Underwriting Department, GPM Life, [P.O. Box 659567, San Antonio, Texas 78265-9567.] 2

Government Personnel Mutual Life Insurance Company (GPM Life)

[P O Box 659567, San Antonio, TX 78265-9567

(210) 357-2222 (800) 938-4765 Fax No. (210) 357-2235 (888) 701-3869]

APPLICATION FOR LIFE INSURANCE - PART 1

1. Employer_____ Plan/Dept._____

PRIMARY PROPOSED INSURED (PPI)	❑ Male ❑ Female	Social Security No.

Home Address Street	City	State	ZIP	Telephone No. Home ( )

Occupation	Annual Income	Date Employed (Mo./Year)	Telephone No. Work ( )

Date of Birth	Age	Driver's License Number and State	Height	Weight

Best time to call _____ A.M. _____ P.M. Time Zone: ❑ Eastern ❑ Central ❑ Mountain ❑ Pacific

2. Plan of Insurance _____ Specified Amount $ _____

Death Benefit Option ❑ A ❑ B ❑ Dividend Option _____ Premium $ _____ per allotment B or M (include any riders)

3. Beneficiary - Name and Relationship.

Owner (if other than PPI) Name, Address, Social Security No. & Age

4. RIDERS: ❑ Children's Term Rider $ _____ ❑ Waiver ❑ Other $ _____

5. a. List Life Insurance in force on Proposed Insured(s):

Company _____ Issue Year: _____

b. Is this insurance intended to replace or change any existing life insurance or annuity in any company, association or society? ❑ Yes ❑ No

6. a. Has any person proposed for insurance missed 3 or more consecutive days of work or normal activity due to illness or injury during the last 120 days? ❑ Yes ❑ No

b. Has any person proposed for insurance been diagnosed as having an Immune Deficiency Disorder, AIDS, AIDS Related Complex (ARC), or tested positive in a HIV related blood test? ❑ Yes ❑ No

c. Has any person proposed for insurance been told by a medical professional that they have 12 months or less to live? ❑ Yes ❑ No

d. During the past 5 years, has any person proposed for insurance been convicted of a felony? ❑ Yes ❑ No

e. During the past 2 years, has any person proposed for insurance had their driver's license suspended or revoked or had 3 or more moving violations? ❑ Yes ❑ No

f. During the past 2 years, has any person proposed for insurance used cocaine, amphetamines, heroin, barbiturates or hallucinogens except on the advice of a physician? ❑ Yes ❑ No

g. Is the Primary Proposed Insured actively at work as of this date? ❑ Yes ❑ No

h. Has any person proposed for insurance used tobacco in any form during the past 12 months? ❑ Yes ❑ No

Details for "yes" answers to 6a-f and "no" answer to 6g: _____

If all of 6a through 6f is answered "No" and 6g is answered "Yes", Primary Proposed Insured will sign Part 1 agreement.

If any of 6a through 6f is answered "Yes" or 6g is answered "No", for any Proposed Insured, complete Application For Life Insurance Part 2 for that Proposed Insured. If Part 2 is completed, Primary Proposed Insured will sign Part 2 Agreement.

If a child rider is applied for, complete Application for Life Insurance Part 2 for all children. Primary Proposed Insured will sign Part 1 and Part 2 agreement.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation (including attendance records), avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 30 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

COLORADO - WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

OREGON, VIRGINIA, VERMONT - FRAUD WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may have violated state law.

WASHINGTON - WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

PART 1 AGREEMENT: I have read this application. I understand the questions and my answers and I represent that all of the information given in it is true, complete and correctly written. I understand that any misstatements as to the health or physical condition of any Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable and suicide period. It is agreed that:

A. This application and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.

B. If there is no material misrepresentation in the application and if the payroll deduction is authorized, effective upon receipt of the application at GPM Life's Home Office interim life insurance equal to the lesser of the amount applied for or $100,000 is provided on the Primary Proposed Insured unless any answer to question 6a through 6f is "Yes" or the answer to 6g is "No", or unless death is by suicide. This coverage continues until this application has been approved for issue, or until the applicant is notified that no insurance will be issued. No interim coverage is in effect on a child rider.

C. Any policy issued by GPM Life shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and complete and correctly written. The Primary Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

Primary Proposed Insured's Signature | Date | City & State Where Application Completed

Owner's/Applicant's Signature (If other than Primary Proposed Insured) | Date | City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Primary Proposed Insured which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and the Medical Information Bureau, Inc. were given to the Primary Proposed Insured. I further certify that I have interviewed the Primary Proposed Insured face to face and witnessed the above signature(s): ❑ Photo ID verified Type of ID _____

To the best of your knowledge:	Yes	No
A. Has any Proposed Insured any existing life insurance or annuity policy or contract?	❑	❑
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?	❑	❑

If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X_____ _____ _____ _____/_____ _____

Writing Agent's Signature | Date | Agent's Name (Please Print) | State / License # | GPM Life Agent #

APPLICATION FOR LIFE INSURANCE - PART 2

Primary Proposed Insured

Complete if Children's Rider is applied for

Name	Son / Daughter	Date of Birth (Month/Day/Year)	Height ft. in.	Weight	Birthplace/Birth State

	YES	NO
7. In the past 10 years, has any person proposed for insurance been diagnosed by or received treatment from a member of the medical profession for:		
a. Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency Virus (HIV), or the antibodies to such virus?	❑	❑
b. Stroke, transient ischemic attack (TIA), heart attack, angina, or any procedure to improve circulation to the heart or brain?	❑	❑
c. Melanoma, internal cancer, or leukemia?	❑	❑
d Alzheimer's disease, dementia, or Parkinson's Disease?	❑	❑
e. Emphysema, liver disease, kidney disease, or kidney failure?	❑	❑
f. Alcohol and/or drug abuse?	❑	❑
g. Diabetes or any diabetic complications including diabetic kidney disease, eye disorder, numbness in hands or feet, diabetic coma, insulin shock, or uncontrolled blood sugars?	❑	❑
h. Seizures or other neurological disorder, depression or other psychiatric disorder?	❑	❑
i. Irregular heart rhythm, enlarged heart, or any other heart disorder?	❑	❑
j. Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring occasional inhaler use)?	❑	❑
k. Lupus (SLE), Muscular Dystrophy, Multiple Sclerosis, or other neuromuscular disorder?	❑	❑
8. During the past 24 months:		
a. Has any person proposed for insurance had or been recommended to have an organ transplant?	❑	❑
b. Been admitted to or confined in a hospital two or more times?	❑	❑
c. Received a diagnosis by a medical professional that would lead to surgery or admission to a hospital or nursing facility?	❑	❑
d. Been confined to a nursing facility or received home health care?	❑	❑

9. Give full details for all "Yes" answers to questions 7a-k and 8a-d.

Person	Question number	Reason, condition, disease, or injury, etc.	Date	Degree of recovery	Name and Address of attending physicians (Street, City, State)

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation (including attendance records), avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 30 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

COLORADO - WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

OREGON, VIRGINIA, VERMONT - FRAUD WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may have violated state law.

WASHINGTON - WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

PART 2 AGREEMENT: I have read this application. I understand the questions and my answers and I represent that all of the information given in it is true, complete and correctly written. I understand that any misstatements as to the health or physical condition of any Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable and suicide period. It is agreed that:

A. This application and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.
B. Any policy issued by GPM Life shall not take effect unless the Policy Date has arrived, the full first premium is paid and the policy is delivered to the owner during the lifetime of all Proposed Insureds, and all the statements and answers given in the application continue to be true and complete and correctly written. The Primary Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.
C. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

Primary Proposed Insured's Signature | Date | City & State Where Application Completed

Owner's/Applicant's Signature (If other than Primary Proposed Insured) | Date | City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of any of the Proposed Insureds which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and the Medical Information Bureau, Inc. were given to the Primary Proposed Insured. I further certify that I have interviewed the Proposed Insured(s) face to face and witnessed the above signature(s): ❑ Photo ID verified Type of ID _____

To the best of your knowledge:	Yes	No
A. Has any Proposed Insured any existing life insurance or annuity policy or contract?	❑	❑
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?	❑	❑

If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X_____ _____ _____ _____/_____ _____

Writing Agent's Signature | Date | Agent's Name (Please Print) | State / License # | GPM Life Agent #

SERFF Tracking #:	*GPML-128493653*	***State Tracking #:***	***Company Tracking #:*** *LA12, ET AL*

State:	*Arkansas*	***Filing Company:***	*Government Personnel Mutual Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB 2013 Authorization Change*		
Project Name/Number:	*MIB 2013 Authorization Change/LA12, et al*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability Certification.pdf Bulletin 15-2009.pdf Regulation 19.pdf Regulation 49.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Redline Differences		
Comments:			
Attachment(s):			
Redline Differences LA97A and LA12A.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
Memorandum of Variability-SLA.pdf Memorandum of Variability-LA12A.pdf			

02AR

ARKANSAS

SUBJECT - Individual Life ___X___ Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER	FLESCH SCORE
LA12A	**51.3**
SLA12	**40.7**

This is to certify that the above referenced form has achieved a Flesch Reading Ease Score, as indicated, and complies with the requirements of Arkansas Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Sean Staggs, FSA, MAAA
Assistant Vice President & Associate Actuary

AR certification2

ARKANSAS

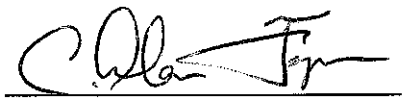
SUBJECT - Individual Life ___X___ Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER

LA12A
SLA12

On behalf of Government Personnel Mutual Life Insurance Company, I hereby certify that I have reviewed Bulletin 15-2009 and the form complies with these guidelines.



C. Alan Ferguson
Senior VP, General Counsel
& Secretary

AR certification1

ARKANSAS

SUBJECT - Individual Life ___X___ Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER

LA12A
SLA12

This submission meets the provisions of Rule and Regulation 19, "Unfair sex discrimination in the sale of insurance" as well as all applicable requirements of this Department.

C. Alan Ferguson
Senior VP, General Counsel
& Secretary

AR certification3

ARKANSAS

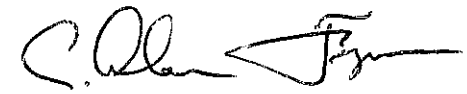
SUBJECT - Individual Life ___X___ Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER

LA12A
SLA12

On behalf of Government Personnel Mutual Life Insurance Company, I hereby certify that the company is in compliance with Regulation 49 in that we will issue a Life and Health notice to each policy owner.



C. Alan Ferguson
Senior VP, General Counsel
& Secretary

Summary
9/24/2012 9:56:42 AM

Differences exist between documents.

New Document:	**Old Document:**
LA12A-no bracs	LA97A-AR
10 pages (250 KB)	11 pages (108 KB)
9/24/2012 9:56:31 AM	9/24/2012 9:56:30 AM
Used to display results.	

Get started: first change is on page 1.

No pages were deleted

How to read this report

Highlight indicates a change.
~~**Deleted**~~ indicates deleted content.
indicates pages were changed.
indicates pages were moved.

Application for Life Insurance

GPM LIFE

Government Personnel Mutual Life Insurance Company
2211 N.E. Loop 410, San Antonio, Texas 78217
P.O. Box 659567, San Antonio, Texas 78265
www.gpmlife.com

PART ONE OF APPLICATION FOR LIFE INSURANCE WITH
GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY (GPM Life)

P.O. Box 659567 San Antonio, Texas 78265-9567
(210) 357-2222 1-800-938-4765 www.gpmlife.com
Fax numbers: Local (210) 357-2235 Toll Free 1-888-701-3869

Application Number

❑ new application ❑ policy change

A. Primary Proposed Insured (PPI)

1. Name (First, Middle Initial, Last)	2. SS/Tax ID No.	3. Birthplace (State/Country)
4. Residence Address (Including City, County, State & Zip)	5. Business Address (Including City, County, State & Zip)	
6. Mailing Address (Including City, County, State & Zip) ❑Check if same as Residence		
7. Residence Phone Number: ( )	8. Business Phone Number: ( )	
9. Driver's License No./State	10. Occupation and Nature of Duties	
11. Annual Income	12. Employer/Military Branch	13. Paygrade
13. Marital Status ❑Married ❑Single ❑Divorced ❑Separated ❑Widowed	14. If Military: Years In | ETS Date |	15. ❑Military ❑Civilian ❑Federal Civil Service

B. All Proposed Insureds List PPI first, then spouse, if applicable)

First Name Middle Last	SS/Tax ID No.	Relation to PPI	Sex M/F	Date of Birth Mo/Day/Yr	Birthplace State/Country	Height Ft. In.	Weight Lbs.
1		PPI					
2							
3							
4							
5							
6							

C. Plan of Insurance

Amount $	Plan	Age of PPI	Requested Policy Date	Mode: ❑Annual ❑SemiAnnual ❑Military Allotment ❑Civil Service Allotment ❑Electronic Funds Transfer ❑Other_____	Automatic Premium Loan Provision ❑Yes ❑No

Complete for Universal Life Plans: Option ❑A ❑B	Planned Premium $	Accidental Death Rider $	Additional Insurance Rider $

❑Waiver of Cost Insurance	❑Guaranteed Benefit Increase $	❑Children's Benefit Rider $ SS#

❑Other Insured Rider $ on	❑Other Insured Rider $ on
❑Other Insured Rider $ on	❑Other Insured Rider $ on
❑Decreasing AIR	❑Other

Complete for all other plans	**Modal Premium: $**	Dividend Option: ❑Cash ❑Reduce Premiums ❑Paid-Up Additions ❑Accumulations ❑Special Modal Dividend Option (10 YT)

Benefits/Riders:	❑Waiver of Premium	❑Accidental Death Benefit $	❑Guaranteed Insurability Option $
❑Spouse Insurance		❑Childrens Insurance Rider $	SS#
❑Additional Term Rider $		❑Other	

❑Paid Up Additions Rider Initial Scheduled Premium $_____ 1035 Exchange
❑Unscheduled Premium $_____ ❑SemiAnnual ❑Quarterly ❑Monthly ❑Yes ❑No

D.-Life Insurance in Force on All Proposed Insureds: ❑ None ❑ Listed Below

Insured	Issue Year	Company	Face Amount	ADB

E.-Beneficiary Designation

Full Name and Address of Primary Beneficiary(ies)	Social Security/Tax ID No.	Date of Birth	Relationship to PPI

Full Name and Address of Contingent Beneficiary(ies)	Social Security/Tax ID No.	Date of Birth	Relationship to PPI

F.-Owner, if other than Primary Proposed Insured

Full Name	Social Security/Tax ID No.	Date of Birth	Relationship to PPI
Address, if other than Primary Proposed Insured's			Branch & Paygrade

Contingent Owner

Full Name	Social Security/Tax ID No.	Date of Birth	Relationship to PPI
Address, if other than Primary Proposed Insured's			Branch & Paygrade

G.-Payor, if other than Primary Proposed Insured

Full Name	Social Security/Tax ID No.	Date of Birth	Relationship to PPI
Address, if other than Primary Proposed Insured's			Branch & Paygrade

SPECIAL REQUESTS OR INSTRUCTIONS

CORRECTIONS AND ADDITIONS (FOR HOME OFFICE USE ONLY)

H.-General Information

The following questions pertain to all Proposed Insureds, including children.	*Yes*	*No*	*Explain fully all "Yes" answers. Indicate question number and the name of the Proposed Insured the answer applies to.*
1. Is the insurance applied for intended to replace any existing insurance or annuity contract?	❑	❑	
2. Are there any application(s) for any life or health insurance now pending or contemplated in any company?	❑	❑	
3. Has any Proposed Insured ever had an application for life insurance or annuity contract declined, postponed, rated or had an application issued other than as applied for?	❑	❑	
4. Is any Proposed Insured NOT a United States citizen? If "Yes", provide immigration card number_____	❑	❑	
5. Has any Proposed Insured ever received or claimed disability or a pension for any injury, sickness or impaired condition?	❑	❑	
6. In the past 5 years, has any Proposed Insured made any flight other than as a passenger or does she / he plan to make such flights in the next five years? (If "Yes", complete Aviation Questionnaire)	❑	❑	
7. In the past 5 years, has any Proposed Insured engaged in: ballooning, cave exploration, parachuting, hang gliding, vehicle racing, scuba diving below 60 feet, mountain climbing or similar sport or avocation? (If "Yes", circle activity and complete appropriate questionnaire)	❑	❑	
8. Does any Proposed Insured have any intention of traveling or living outside the USA or Canada in the next 2 years, except for vacation?	❑	❑	
9. In the past 5 years has any Proposed Insured been convicted of 2 or more moving violations, or driving under the influence of drugs or alcohol, or had a driver's license suspended or revoked? (If "Yes", give details.)	❑	❑	
10. In the past 10 years has any Proposed Insured used marijuana, cocaine, heroin, barbiturates, hallucinogens, or amphetamines, unless on the advice of a physician, or been convicted for the use or possession of alcohol; or received advice, counseling or treatment as the result of the use of alcohol or drugs; or used or been convicted for the use or possession of any narcotic, stimulant, sedative, or hallucinogenic drug?	❑	❑	
11. In the past 10 years has any Proposed Insured been convicted of a felony?	❑	❑	
12. (For military only) Does any Proposed Insured serve in Special Forces, Rangers, Airborne, or Navy SEALs?	❑	❑	

I.- Physical Data, Health and Medical History

The following questions pertain to all Proposed Insureds, including children, (Circle ALL applicable items)	Yes	No	Explain fully all "Yes" answers. Include name of Proposed Insured and question number the answer applies to, specific diagnosis, treatments, results, dates of onset & recovery, and names & addresses of all doctors & hospitals.
1. (a) Does any Proposed Insured currently use tobacco in any form? (If "yes", describe tobacco use below.) Who? _____ ❑ Cigarettes ___ packs per day ❑ Cigars ❑ Pipe ❑ Chewing or other "smokeless" tobacco	❑	❑	
(b) Is any Proposed Insured a former user of tobacco? (If "yes", describe tobacco use below.) Who? _____ Month/Year quit _____ Describe past use of tobacco_____	❑	❑	
2. Has any Proposed Insured ever been diagnosed with or treated for:			
(a) high blood pressure, chest pain or pressure, angina, heart attack, abnormal heartbeat, murmur, stroke, or any other circulatory system disorder?	❑	❑	
(b) cancer, Hodgkin's disease, leukemia, or any tumor or polyp?	❑	❑	
(c) epilepsy, convulsions, seizures, severe headaches, paralysis, nervous breakdown, psychosis, or any mental or nervous disorder?	❑	❑	
3. In the past 10 years, has any Proposed Insured had or been treated for:			
(a) diabetes, anemia, polycythemia, hemophilia; disorder or enlargement of any gland, including lymph glands?	❑	❑	
(b) persistent fever, cough, diarrhea, weakness or infection?	❑	❑	
(c) asthma, bronchitis, emphysema, tuberculosis, pneumonia, or any infection or other disorder of the respiratory system?	❑	❑	
(d) ulcer, gastritis, colitis, hepatitis, cirrhosis, pancreatitis, or any other disorder of liver, gallbladder, or intestines?	❑	❑	
(e) any disorder of the kidneys, bladder, prostate, reproductive organs or breasts; or any sexually transmitted disease?	❑	❑	
(f) any disorder of the back, spine, bones, joints or muscles?	❑	❑	
4. In the past 10 years has any Proposed Insured:			
(a) been diagnosed by a member of the medical profession as having, or been treated for, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV disease?	❑	❑	
(b) tested positive for antibodies to the HIV virus?	❑	❑	
5. In addition to any doctors or hospitals listed above, in the last 5 years, has any Proposed Insured:			
(a) been treated, examined or observed in a hospital, clinic, or other medical facility?	❑	❑	
(b) consulted with any other doctors?	❑	❑	
(c) been treated for, diagnosed as having, or had an operation for any other cause(s) not listed above?	❑	❑	
6. Within the past year, has the weight of any Proposed Insured changed 10 pounds or more? (For children under 16, report only loss)	❑	❑	
7. Has any family member (parents, siblings) of the proposed Insured had heart disease, stroke, diabetes or cancer prior to age 60?	❑	❑	
8.			

PPI'S Family History	Living: age	Deceased: age at death	Cause of death
Father			
Mother			
Brothers			
Sisters			

Received with app: $_____cash ❑Civil Service 1199A and Bank Allotment Authorization
❑Military Allotment Request Copy or Certification ❑None of the above received. The application is to be considered on a C.O.D. basis.

AGREEMENT: I have read this application, and represent that all of the information given in it is true, complete and correctly written. It is agreed that:

A. The application consists of Part One, Part Two (if required), and any amendments or supplements to either of said parts. It will be relied on by GPM Life as the basis of any policy which may be issued.

B. No agent, broker, or medical examiner can accept risks, make or change contracts, or waive any of GPM Life's rights, conditions, or requirements. Only an authorized officer of GPM Life can do these things.

C. Except as may be provided by the Conditional Receipt, there will be no insurance unless and until a policy is delivered and the first modal premium paid in full while the insurability of the Proposed Insured(s) is still as described in the application; there must have been no material change in health or other risk factors. I will notify GPM Life if any such change takes place after I sign the application and before such delivery and payment.

D. If the Conditional Receipt is delivered to the Applicant, insurance will start before a policy is delivered only if all the conditions set forth in such receipt are met. If I have received such receipt, its provisions have been explained to me and I fully understand them.

E. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for Home Office "Corrections and Additions". But where the law so requires, written consent must be obtained for any change in the application.

BACKUP WITHHOLDING CERTIFICATION (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me or my minor children, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. I further authorize all said sources, except Medical Information Bureau, Inc., to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s).

Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required.

I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 30 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled " Information Practices", "Investigative Consumer Reports", and "Medical Information Bureau, Inc." from GPM Life.

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Primary Proposed Insured (if minor, parent or legal guardian)	*** * * Date Signed * * ***	Signature of Agent
Signature of Spouse, if a Proposed Insured	Signature of Other Proposed Insured (if age 15 or over)	Agent's Printed Name / GPM Life Agent No.
Signature of Proposed Owner (if not Primary Proposed Insured)	Signature of Other Proposed Insured (if age 15 or over)	Agent's License No. / State
Signature of Other Proposed Insured (if age 15 or over)	Signature of Other Proposed Insured (if age 15 or over)	Signed at (City, State, Zip)

CONDITIONAL RECEIPT

Unless every condition in paragraph 2 is met exactly, no insurance will take effect prior to policy delivery. No agent, broker, or medical examiner is authorized to change or waive any of such conditions. If, within the past 12 months, any Proposed insured has had or been treated for any known heart trouble, stroke, AIDS or cancer, payment cannot be accepted with the application.

All checks must be made payable to GPM Life. Do not make check payable to the agent or leave the payee blank.

Received from_____$_____cash or, in lieu of cash,

❑ Military Allotment Request Copy or Certification, or ❑ Civil Service 1199A & Bank Allotment Authorization

given with application for life insurance to Government Personnel Mutual Life Insurance Company (GPM Life), which application bears the same date as this receipt. This receipt is void if the item given for it fails to result in payment.

1. If all the conditions in Paragraph 2 are met exactly, then insurance subject to the terms of the policy applied for, but not to exceed the limit in Paragraph 3, will start at the "Conditional Effective Time", defined as the later of: (a) when Part One of the application has been completed; or (b) when all medical exams and tests required by GPM Life's rules have been completed, and all required blood, urine, and/or oral fluid specimen(s) have been furnished.
2. Insurance will not start at the Conditional Effective Time unless all these conditions are met:
   (a) At the Conditional Effective Time, all of the Proposed Insureds must be risks acceptable to GPM Life under its rules, limits, and standards of insurability for the amount and plan applied for, without change, and at the standard rate of premium.
   (b) The sum of money, if any, given for this receipt must be at least as much as the full first premium for the plan, amount of insurance and the mode of payment stated in the application.
   (c) All medical exams and tests required by GPM Life's rules must be completed, and all required specimens of blood, urine, and/or oral fluid specimen(s) furnished, within 60 days from the date of Part One of the application.
   (d) At the Conditional Effective Time, the state of health and all factors affecting the insurability of the Proposed Insured(s) must be as stated in the application.
   (e) If a Military Allotment Request Copy or Certification or a Civil Service form 1199A and Bank Allotment Authority has been received by GPM Life in lieu of cash, the allotment 1) must not have been canceled or discontinued for any reason before GPM Life receives the full first monthly premium corresponding to the mode of payment stated in the application, and 2) must result in payment to GPM Life of such full first monthly premium by the earlier of the policy Effective Date or 14 weeks after the Conditional Effective Time.
3. The total amount of life insurance, including accidental death benefits, which may become effective on any Proposed Insured prior to the effective date of a delivered policy for which the full first premium has been received by reason of this and any other receipts will not exceed $150,000.
4. If one or more of the conditions in Paragraph 2 is not met exactly, or if death of a Proposed Insured results from suicide, there will be no liability on the part of GPM Life except to return any money received.

C. Alan Ferguson, Secretary

I certify that I have explained all of the terms of this receipt to the Applicant(s).

Date:_____ X_____
Signature of Agent

The following is a copy of the Agreement signed in connection with the application.

AGREEMENT

AGREEMENT: I have read this application, and represent that all of the information given in it is true, complete, and correctly written to the best of my knowledge and belief. It is agreed that:

A. The application consists of Part One, Part Two (if required), and any amendments or supplements to either of said parts. It will be relied on by GPM Life as the basis of any policy which may be issued.

B. No agent, broker, or medical examiner can accept risks, make or change contracts, or waive any of GPM Life's rights, conditions, or requirements. Only an authorized officer of GPM Life can do these things.

C. Except as may be provided by the Conditional Receipt, there will be no insurance unless and until a policy is delivered and the first modal premium paid in full while the insurability of the Proposed Insured(s) is still as described in the application; there must have been no material change in health or other risk factors. I will notify GPM Life if any such change takes place after I sign the application and before such delivery and payment.

D. If the Conditional Receipt is delivered to the Applicant, insurance will start before a policy is delivered only if all the conditions set forth in such receipt are met. If I have received such receipt, its provisions have been explained to me and I fully understand them.

E. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for Home Office "Corrections and Additions". But where the law so requires, written consent must be obtained for any change in the application.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

AGENT'S REPORT AND CERTIFICATE

		Yes	No
1.	Is the Applicant or any Proposed Insured a current or past GPM Life policyowner or Insured?	❑	❑
2.	As far as you know, will the insurance applied for replace any existing insurance or annuity?	❑	❑
	If "Yes", did you write the replaced policy?	❑	❑
	Reason(s) for replacement:		

_____

_____

_____

3.	Are there any Proposed Insureds whom you did not see when you took this application?	❑	❑
4.	Are there any Proposed Insureds who do not reside with the Primary Proposed Insured?	❑	❑
5.	Have you submitted or do you plan to submit this case to any other company?	❑	❑
6.	Has any Proposed Insured used a different last name in the past 5 years? (Provide full details of all "Yes" answers)	❑	❑

_____

_____

_____

7. To clarify any question or obtain a telephone interview, the following is needed **(Please remind the Primary Proposed Insured about the possibility of a call)**:

   Home Telephone: ( ) _____ Best time to call _____

   Business Telephone: ( ) _____ Best time to call _____

8. Indicate below how well you know the Primary Proposed Insured (Applicant, if Primary Proposed Insured is under age 18).

   ❑ Slightly for ____ years ❑ Well for____ years ❑ Just met ❑ Related by blood or marriage; he/she is my _____

9. Is medical exam or blood profile required? ❑ Yes ❑ No

   Date Scheduled_____ Paramed/Examiner _____

10. If Primary Proposed Insured is below 18, how much life insurance is in force and applied for on:

    Mother_____ Father_____ Siblings_____

11. Request for ❑ Additional ❑ Alternate policy.....

    Plan_____ Amount_____ Benefits _____

    Beneficiary_____ Other Differences _____

12. Source of Prospect

    ❑ Existing Client ❑ Relative of Client ❑ Referred Lead ❑ Personal Acquaintance for _____ years.

    ❑ Cold Canvas ❑ Direct Mail ❑ Prospect approached me without being solicited

AGENT'S REPORT AND CERTIFICATE

13. Use of Insurance (check one)

❑ Personal (If checked, complete question 14) ❑ Business Related (If checked, complete question 15)

14.a Purpose of Personal Insurance with expectation of how proceeds will be utilized (check one most applicable)

❑ Create an Immediate Estate for Heirs ❑ Surviving Income Protection
❑ Retirement Income Supplement ❑ Provide Estate Liquidity
❑ Mortgage Protection/Acceleration ❑ Secure Other Personal Debt
❑ Supplement and Protect Personal Savings ❑ Other_____

14.b How was amount of Personal Insurance determined? (check one most applicable).

❑ Needs Analysis with Assistance from Agent ❑ Needs Analysis with Computer Output Assistance
❑ Need Pre-Determined by Applicant ❑ Other_____

15.a Purpose of Business Insurance (check one most applicable).

❑ Business Continuation Plan (Buy/Sell) ❑ Key Person Plan ❑ Deferred Compensation Plan
❑ Split Dollar Plan ❑ Executive Bonus Plan ❑ Secure Business Debt
❑ Other_____

15.b Business Data ❑ Corporation ❑ Partnership ❑ Sole Proprietorship

If available, attach a copy of the business' latest audited financial statements (Balance Sheet and Profit and Loss).

In addition, please complete the following questions:

i. Date Corporation, Partnership or Business Established_____
ii. Estimated Net Worth of Business $_____
iii. Current Value of Primary Proposed Insured's Interest (based on % of ownership) $_____
iv. Net Annual Income of Business $_____
v. If Proposed Insured is an officer or partner, are all of the remaining officers or partners applying for insurance at this time? ❑ Yes ❑ No (if "No", explain in remarks)

REMARKS_____

_____

_____

_____

I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of any person proposed for insurance which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices, the Federal Fair Credit Reporting Act, and Medical Information Bureau, Inc., were given to the Primary Proposed Insured.

Date	Agent's Signature	Joint Agent's Signature
	Agent's Printed Name/GPM Life Agent No.	Joint Agent's Printed Name/GPM Life Agent No.
	Agent's License No./State	Joint Agent's License No./State

Government Personnel Mutual Life Insurance Company
P.O. Box 659567
San Antonio, Texas 78265-9567
www.gpmlife.com

NOTICE UNDER THE FAIR CREDIT REPORTING ACT AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

INVESTIGATIVE CONSUMER REPORTS: As part of the underwriting process, we may request an investigative consumer report from a consumer reporting agency for the purpose of obtaining information about your character, reputation and mode of living, through personal interviews with your friends, neighbors, and associates. You may ask for a personal interview with the consumer reporting agency in connection with any investigative consumer report which may be prepared. You are also entitled, upon written request pursuant to law, to be informed of the nature and scope of the investigation and to receive a copy of the report.

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

For further information, write the Underwriting Department, GPM Life, P.O. Box 659567, San Antonio, Texas 78265-9567.

Memorandum of Variability
Explanation of Variable Statements and Fields
For Government Personnel Mutual Life Insurance Company
Form SLA12

Each variable section, statement or field is denoted by [brackets] and annotated with numbers in RED. The explanations below follow the order in which the variable fields appear in the form.

Variable Statements/Fields	*How or When Used*
Page 1	
1. [P.O. Box 659567, San Antonio, Texas 78265-9567]	This is the company's mailing address.
2. [210-357-2222, (800) 938-4765]	This is the company's toll free and local numbers.
3. [210-357-2235, (888) 701-3869]	This is the company's local and toll free fax numbers.

Memorandum of Variability
Explanation of Variable Statements and Fields
For Government Personnel Mutual Life Insurance Company
Form LA12A

Each variable section, statement or field is denoted by [brackets] and annotated with numbers in RED. The explanations below follow the order in which the variable fields appear in the form.

Variable Statements/Fields	*How or When Used*
Page 1	
1. [2211 N.E. loop 410, San Antonio, TX 78217]	This is the company's physical address
2. [P.O. Box 659567, San Antonio, TX 78265]	This is the company's mailing address
3. [www.gpmlife.com]	This is the company's website address
4. [210-357-2222]	This is the company's local phone number
5. [1-800-938-4765]	This is the company's toll free phone number
6. [210-357-2235, 1-888-701-3869]	This is the company's local and toll free fax numbers.
7. [866-692-6901, 866-346-3642]	This is MIB's phone numbers.
8. [50 Braintree Hill Park, Suite 400, Braintree Massachusetts 02184-8734]	This is MIB's address.
9. [www.mib.com]	This is the website for MIB.